

		FOR OHF USE				

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0036749</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Aviston Terrace</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>07/01/2001</u> to <u>06/30/2002</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>349 West First Street</u> <u>Aviston</u> <u>62216</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>Clinton</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
Telephone Number: <u>(618) 228-7040</u> Fax # <u>(618) 228-7002</u>		Paid Preparer (Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Altschuler, Melvoin and Glasser, LLP</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u> (Telephone) <u>(312) 634-3400</u> Fax # <u>(312) 634-5518</u>	
IDPA ID Number: <u>371238076002</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>01/01/91</u>			
Type of Ownership:			
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT			
<input checked="" type="checkbox"/> Charitable Corp.			
<input type="checkbox"/> Trust			
IRS Exemption Code <u>501 (c)(3)</u>			
<input type="checkbox"/> PROPRIETARY			
<input type="checkbox"/> Individual			
<input type="checkbox"/> Partnership			
<input type="checkbox"/> Corporation			
<input type="checkbox"/> "Sub-S" Corp.			
<input type="checkbox"/> Limited Liability Co.			
<input type="checkbox"/> Trust			
<input type="checkbox"/> Other _____			
GOVERNMENTAL			
<input type="checkbox"/> State			
<input type="checkbox"/> County			
<input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>Christine A. Hanover</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page			

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Terrace# 0036749 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	<u>16</u>	ICF/DD 16 or Less	<u>16</u>	<u>5,840</u>	6
7	<u>16</u>	TOTALS	<u>16</u>	<u>5,840</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	<u>5,151</u>			<u>5,151</u>	13
14	TOTALS	<u>5,151</u>			<u>5,151</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 88.20%

D. How many bed-hold days during this year were paid by Public Aid?

81 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒NO ☐Non-allowable costs have been
eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐NO ☒

I. On what date did you start providing long term care at this location?

Date started 01/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒Date 01/01/91NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐NO ☒

If YES, enter number

of beds certified 0 and days of care provided N/AMedicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL ☒

MODIFIED

CASH* ☐CASH* ☐

Is your fiscal year identical to your tax year?

YES ☒ NO ☐Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Terrace

0036749

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3**	Total 4					9	10	
	A. General Services											
1	Dietary	18,451	1,433	1,534	21,418		21,418		21,418			1
2	Food Purchase		22,963		22,963		22,963	(2,722)	20,241			2
3	Housekeeping		2,971		2,971		2,971		2,971			3
4	Laundry		726		726		726		726			4
5	Heat and Other Utilities			7,992	7,992		7,992		7,992			5
6	Maintenance	3,730		7,177	10,907		10,907	31	10,938			6
7	Other (specify):*											7
8	TOTAL General Services	22,181	28,093	16,703	66,977		66,977	(2,691)	64,286			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	151,514	1,533	2,939	155,986		155,986		155,986			10
10a	Therapy			842	842		842		842			10a
11	Activities		2,664	97	2,761		2,761		2,761			11
12	Social Services			1,624	1,624		1,624		1,624			12
13	Nurse Aide Training	1,809		1,271	3,080		3,080		3,080			13
14	Program Transportation			704	704		704		704			14
15	Other (specify):* Routine Dental			1,759	1,759		1,759		1,759			15
16	TOTAL Health Care and Programs	153,323	4,197	10,436	167,956		167,956		167,956			16
	C. General Administration											
17	Administrative	16,813		62,700	79,513		79,513	5,700	85,213			17
18	Directors Fees							4,576	4,576			18
19	Professional Services			670	670		670	9,937	10,607			19
20	Dues, Fees, Subscriptions & Promotions			2,307	2,307		2,307	75	2,382			20
21	Clerical & General Office Expenses		1,229	3,026	4,255		4,255	5,443	9,698			21
22	Employee Benefits & Payroll Taxes			14,794	14,794		14,794	24,474	39,268			22
23	Inservice Training & Education											23
24	Travel and Seminar			796	796		796	475	1,271			24
25	Other Admin. Staff Transportation			1,040	1,040		1,040	265	1,305			25
26	Insurance-Prop.Liab.Malpractice			(751)	(751)		(751)	4,659	3,908			26
27	Other (specify):*											27
28	TOTAL General Administration	16,813	1,229	84,582	102,624		102,624	55,604	158,228			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	192,317	33,519	111,721	337,557		337,557	52,913	390,470			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Aviston Terrace

#0036749

Report Period Beginning: 07/01/2001 Ending: 06/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7**	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			16,425	16,425		16,425	259	16,684			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			43,201	43,201		43,201	3,805	47,006			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,067	3,067		3,067	11	3,078			35
36	Other (specify):*											36
37	TOTAL Ownership			62,693	62,693		62,693	4,075	66,768			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers							444	444			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			26,051	26,051		26,051	8,685	34,736			42
43	Other (specify):* Nonallowable Costs			182,158	182,158		182,158	(182,158)				43
44	TOTAL Special Cost Centers			208,209	208,209		208,209	(173,029)	35,180			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	192,317	33,519	382,623	608,459		608,459	(116,041)	492,418			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

** See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

	1	2	3	
	Amount	Refer- ence	OHF USE ONLY	
NON-ALLOWABLE EXPENSES				
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs	(179,425)	43		3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(458)	43		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(83)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties	(2,272)	43		18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(3)	43		24
25 Fund Raising, Advertising and Promotional				25
Income Taxes and Illinois Personal				
26 Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising				28
29 Other-Attach Schedule See schedule 5A	(203)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (182,444)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
Adjustments for Related Organization			
34 Costs (Schedule VII)	66,403		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ 66,403		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B))	\$ (116,041)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		X	\$		38
39					39
40 Gift and Coffee Shops		X			40
41 Barber and Beauty Shops		X			41
42 Laboratory and Radiology		X			42
43 Prescription Drugs		X			43
44 Exceptional Care Program		X			44
45 Other-Attach Schedule		X			45
46 Other-Attach Schedule		X			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Terrace
Provider #0036749
June 30, 2002

Schedule 5A

VI. Adjustment Detail

Line 29 - Other (Specify)

	<u>Amount</u>	<u>Reference</u>
Out of period legal fees	(170)	19
Miscellaneous income offset	<u>(33)</u>	21
TOTAL - Line 29	<u><u>(203)</u></u>	

SEE ACCOUNTANTS' COMPILATION REPORT

Aviston Terrace

ID# 0036749

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

06/30/2002

[illegible]

Summary B

06/30/2002

[illegible]

Facility Name & ID Number Aviston Terrace# 0036749

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Progressive Housing, Inc.	100.00	See attached Related Party Schedule		See attached Related Party Schedule		N/A
See Attached Schedule 7A						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	6 Repairs & maintenance	\$	Center for Residential Management, Inc.	**	\$ 31	\$ 31	1
2	V	18 Board fees		Center for Residential Management, Inc.	**	953	953	2
3	V	19 Professional fees		Center for Residential Management, Inc.	**	2,354	2,354	3
4	V	20 Licenses, dues, & subs		Center for Residential Management, Inc.	**	71	71	4
5	V	21 Office supplies & telephone		Center for Residential Management, Inc.	**	4,686	4,686	5
6	V	22 Emp. benefits & payroll taxes		Center for Residential Management, Inc.	**	16,040	16,040	6
7	V	24 Travel & seminar		Center for Residential Management, Inc.	**	62	62	7
8	V	25 Vehicle expense		Center for Residential Management, Inc.	**	253	253	8
9	V	26 Vehicle, fire & liab insurance		Center for Residential Management, Inc.	**	38	38	9
10	V	30 Depreciation		Center for Residential Management, Inc.	**	259	259	10
11	V	32 Interest expense		Center for Residential Management, Inc.	**	288	288	11
12	V	35 Vehicle lease		Center for Residential Management, Inc.	**	11	11	12
13	V	39 Ancillary service centers		Center for Residential Management, Inc.	**	444	444	13
14	Total		\$			\$ 25,490	\$ *	25,490 14

** Center for Residential Management, Inc. is Progressive Housing, Inc.'s parent company.

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Schedule VII - Related Parties**Page 6, Section A, Column 2, Related Nursing Homes****Related Party Schedule**

Name	Facility Name	City
Progressive Housing, Inc.	Gateway Terrace	Irvington
	Aviston Terrace	Aviston
	Briarbrook Place	East Peoria
	Joshua Manor	Hoyleton
	Terra Estates	Hoyleton
	Park Place	Pana
	Harris Place	East Peoria
	Okawville	Okawville
	Billy Goat Hill	Mt. Vernon
	Country Club Hills (185th St.)	Country Club Hills
	Country Club Hills (Lee St.)	Country Club Hills
	Galaxy	Woodlawn
	Perrine	Centralia
	Troy	Troy
	Western Gardens	Mt. Vernon
	Cardinal	Woodlawn
Residential Centers, Inc.	Lakeview Living Center	Chicago
	Countryview Living Center	Latham
	Sparta Terrace	Sparta
	Taylorville Terrace	Taylorville
	Ellner Terrace	Evansville
Caravilla Resident Centers, Inc.	Mt. Vernon Care Center	Mt. Vernon
	Jeffersonian Care Center	Mt. Vernon
	Casey Care Center	Mt. Vernon

Schedule VII, Related Parties**Page 6, Section A, Column 3, Other Related Business Entities**

Name	City	Type of Business
Center for Residential Management, Inc.	Peoria	Management/Holding Co.
Residential Centers, Inc.	Peoria	ICF/DD Provider
Progressive Housing, Inc.	Peoria	ICF/DD Provider
Caravilla Charitable Corporation	Mt. Vernon	Lessor
Caravilla Resident Centers, Inc.	Mt. Vernon	SNF/ICF Provider

Facility Name & ID Number Aviston Terrace# 0036749Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17 Administrative service fees	\$	Progressive Housing, Inc.	100.00%	\$ 5,700	\$ 5,700	15
16	V	18 Board fees		Progressive Housing, Inc.	100.00%	3,623	3,623	16
17	V	19 Professional fees		Progressive Housing, Inc.	100.00%	7,753	7,753	17
18	V	20 License, dues & subscriptions		Progressive Housing, Inc.	100.00%	4	4	18
19	V	21 Office supplies & telephone		Progressive Housing, Inc.	100.00%	790	790	19
20	V	22 Emp. benefits & payroll taxes		Progressive Housing, Inc.	100.00%	5,712	5,712	20
21	V	24 Travel & seminar		Progressive Housing, Inc.	100.00%	413	413	21
22	V	25 Vehicle expense		Progressive Housing, Inc.	100.00%	12	12	22
23	V	26 Vehicle, fire & liab insurance		Progressive Housing, Inc.	100.00%	4,621	4,621	23
24	V	32 Interest expense		Progressive Housing, Inc.	100.00%	3,600	3,600	24
25	V	42 Provider fees		Progressive Housing, Inc.	100.00%	8,685	8,685	25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 40,913	\$ * 40,913	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Cora Flota	Director	Board Member	None	4,247	2 hrs/mtg		Directors Fees	\$ 553	L 18, C 8	1
2	Darrell Boehne	President	Board Member	None	14,669	2 hrs/mtg		Directors Fees	731	L 18, C 8	2
3	Edward Childers	Vice President	Board Member	None	14,484	2 hrs/mtg		Directors Fees	716	L 18, C 8	3
4	Kay Schuman Johnson	Director	Board Member	None	2,118	2 hrs/mtg		Directors Fees	282	L 18, C 8	4
5	Orland Bauer	Treasurer	Board Member	None	9,686	2 hrs/mtg		Directors Fees	714	L 18, C 8	5
6	Ron Schroeder	Secretary	Board Member	None	14,689	2 hrs/mtg		Directors Fees	711	L 18, C 8	6
7	Merla McCloud	Recorder	Administrative	None	17,689	2 hrs/mtg		Directors Fees	711	L 18, C 8	7
8	Robert Bauer	Board Member	Board Member	None	13,842	2 hrs/mtg		Directors Fees	158	L 18, C 8	8
9											9
10											10
11											11
12	See attached Schedule 7A										12
13								TOTAL	\$ 4,576		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

SCHEDULE 7A
Board of Directors Fees

	Ron <u>Schroeder</u>	Darrell <u>Boehne</u>	Edward <u>Childers</u>	Bob <u>Bauer</u>	Cora <u>Flota</u>	Orland <u>Bauer</u>	Kay Schuman <u>Johnson</u>	Roger <u>Ryan</u>	Ronald <u>O'Daniell</u>	William <u>Armstrong</u>	Kay <u>Baker</u>	Merla <u>McCloud</u>	Totals
Residential Centers, Inc.													
Lakeview Living Center	3,757	3,606	3,606	3,606								3,606	18,181
Sparta Terrace	415	398	398	398								398	2,006
Ellner Terrace	415	398	398	398								398	2,006
Taylorville Terrace	415	398	398	398								398	2,006
Total RCI	5,000	4,800	4,800	4,800	0	0	0	0	0	0	0	4,800	24,200
Progressive Housing, Inc.													
Aviston Terrace	553	576	553		553	553	282					553	3,623
Harris Place	553	576	553		553	553	282					553	3,623
Briarbrook Place	553	576	553		553	553	282					553	3,623
Joshua Manor	553	576	553		553	553	282					553	3,623
Terra Estates	553	576	553		553	553	282					553	3,623
Park Place	553	576	553		553	553	282					553	3,623
Okawville	207	216	207		207	207	106					207	1,358
Perrine	138	144	138		138	138	71					138	906
Western Gardens	138	144	138		138	138	71					138	905
Galaxy	276	288	276		276	276	141					276	1,811
Billy Goat Hill	276	288	276		276	276	141					276	1,811
Troy	138	144	138		138	138	71					138	906
Country Club Hills - 185th St.	207	216	207		207	207	106					207	1,357
Country Club Hills - Lee St.	101	101	101		101	101	0					101	608
Total PHI	4,800	5,000	4,800	0	4,800	4,800	2,400	0	0	0	0	4,800	31,400
Caravilla Resident Centers, Inc.													
Mt. Vernon				980				871	871	871	871	871	5,338
Jeffersonian Care Center				996				885	885	885	885	885	5,421
Casey Care Center				1,624				1,443	1,443	1,443	1,443	1,443	8,841
Total CRC	0	0	0	3,600	0	0	0	3,200	3,200	3,200	3,200	3,200	19,600
Center for Residential Management, Inc. *													
	5,600	5,600	5,600	5,600		5,600						5,600	33,600
Total Board of Directors Fees	15,400	15,400	15,200	14,000	4,800	10,400	2,400	3,200	3,200	3,200	3,200	18,400	108,800

* Center for Residential Management, Inc.'s board fees are allocated to each facility.

Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions with the nursing home during the reporting period.

See Accountants' Compilation Report

Facility Name & ID Number Aviston Terrace# 0036749 Report Period Beginning: 07/01/2001Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Center for Residential Management, Inc.
 Street Address 4239 W. War Memorial Drive, Suite 302
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 685-0595
 Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	19	Professional fees	Bed days available	21	\$ 7,680	\$	5,840	\$ 216	1
2	20	Licenses, dues, & subs	Bed days available	21	(100)		5,840	(3)	2
3	21	Office supplies & telephone	Bed days available	21	(861)		5,840	(25)	3
4	24	Travel & seminar	Bed days available	21	(580)		5,840	(17)	4
5	25	Vehicle expense	Bed days available	21	8,145		5,840	229	5
6	26	Vehicle, fire & liab insurance	Bed days available	21	1,353		5,840	38	6
7	30	Depreciation	Bed days available	21	9,194		5,840	259	7
8	32	Interest expense	Bed days available	21	8,154		5,840	229	8
9	35	Vehicle lease	Bed days available	21	375		5,840	11	9
10	39	Ancillary service centers	Bed days available	21	15,783		5,840	444	10
11									11
12									12
13									13
14									14
15									15
16	6	Repairs & maintenance	Direct method					31	16
17	18	Board fees	Direct method					953	17
18	19	Professional fees	Direct method					2,138	18
19	20	Licenses, dues, & subs	Direct method					74	19
20	21	Office supplies & telephone	Direct method					4,711	20
21	22	Emp. benefits & payroll taxes	Direct method					16,040	21
22	24	Travel & seminar	Direct method					79	22
23	25	Vehicle expense	Direct method					24	23
24	32	Interest expense	Direct method					59	24
25	TOTALS				\$ 49,143	\$		\$ 25,490	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace# 0036749 Report Period Beginning: 07/01/2001Ending: 6/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Progressive Housing, Inc.Street Address 4239 W. War Memorial Drive, Suite 302City / State / Zip Code Peoria, IL 61614Phone Number (309) 685-0595Fax Number (309) 685-8463

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	Administrative service fees	# of beds, direct cost	142	\$ 41,025	\$	16	\$ 5,700	1
2	18	Board fees	# of beds, direct cost	142	31,402		16	3,623	2
3	19	Professional fees	# of beds, direct cost	142	66,457		16	7,753	3
4	20	License, dues & subscriptions	# of beds	142	35		16	4	4
5	21	Office supplies & telephone	# of beds	142	6,942		16	790	5
6	22	Emp. benefits & payroll taxes	# of beds	142	1,438		16	169	6
7	24	Travel & seminar	# of beds	142	3,576		16	413	7
8	25	Vehicle expense	# of beds	142	107		16	12	8
9	32	Interest expense	# of beds, direct cost	142	31,230		16	3,600	9
10	42	Provider fees	# of beds, direct cost	142	53,342		16	8,685	10
11									11
12									12
13									13
14									14
15	22	Emp. benefits & payroll taxes	Direct method					5,543	15
16	26	Vehicle, fire & liab insurance	Direct method					4,621	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 235,554	\$		\$ 40,913	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace # 0036749 Report Period Beginning: 07/01/2001 Ending: 06/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1 Name of Lender	2 Related**		3 Purpose of Loan	4 Monthly Payment Required	5 Date of Note	6 Amount of Note		7 Maturity Date	8 Interest Rate (4 Digits)	9 Reporting Period Interest Expense	10
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	IL Health Fac. Auth.-Bond		x	Acquisition of facility	None	03/01/93	\$ 4,527,000	\$ 655,690	08/15/16	Various	\$ 51,702	1
2	Lease Obligation-NCS		x	Hardware/Software	\$94.00	10/31/98	3,756	1,300	09/30/03	0.1429	144	2
3												3
4												4
5												5
	Working Capital											
6	Community Bank of Galesburg		x	Working Capital	None	08/23/02	286,000	26,592	02/23/03	0.0950	2,958	6
7												7
8												8
9	TOTAL Facility Related				\$94.00		\$ 4,816,756	\$ 683,582			\$ 58,056	9
	B. Non-Facility Related*											
10											21	10
11											(11,238)	11
12											(62)	12
13											229	13
14	TOTAL Non-Facility Related						\$	\$			(11,050)	14
15	TOTALS (line 9+line14)						\$ 4,816,756	\$ 683,582			\$ 47,006	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Aviston Terrace**# **0036749** Report Period Beginning: **07/01/2001** Ending: **06/30/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

<div style="border: 1px solid black; padding: 2px; display: inline-block;"> Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report. </div>																												
1. Real Estate Tax accrual used on 2001 report.		\$	1																									
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	2																									
3. Under or (over) accrual (line 2 minus line 1).		\$	3																									
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		\$ N/A	4																									
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	5																									
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		\$	6																									
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	7																									
Real Estate Tax History:																												
Real Estate Tax Bill for Calendar Year:	<table border="1"> <tr><td>1997</td><td>8</td></tr> <tr><td>1998</td><td>9</td></tr> <tr><td>1999</td><td>10</td></tr> <tr><td>2000</td><td>11</td></tr> <tr><td>2001</td><td>12</td></tr> </table>	1997	8	1998	9	1999	10	2000	11	2001	12	<table border="1"> <tr> <td></td> <td>FOR OHF USE ONLY</td> <td></td> </tr> <tr> <td>13</td> <td>FROM R. E. TAX STATEMENT FOR 2001 \$</td> <td>13</td> </tr> <tr> <td>14</td> <td>PLUS APPEAL COST FROM LINE 5 \$</td> <td>14</td> </tr> <tr> <td>15</td> <td>LESS REFUND FROM LINE 6 \$</td> <td>15</td> </tr> <tr> <td>16</td> <td>AMOUNT TO USE FOR RATE CALCULATION \$</td> <td>16</td> </tr> </table>			FOR OHF USE ONLY		13	FROM R. E. TAX STATEMENT FOR 2001 \$	13	14	PLUS APPEAL COST FROM LINE 5 \$	14	15	LESS REFUND FROM LINE 6 \$	15	16	AMOUNT TO USE FOR RATE CALCULATION \$	16
1997	8																											
1998	9																											
1999	10																											
2000	11																											
2001	12																											
	FOR OHF USE ONLY																											
13	FROM R. E. TAX STATEMENT FOR 2001 \$	13																										
14	PLUS APPEAL COST FROM LINE 5 \$	14																										
15	LESS REFUND FROM LINE 6 \$	15																										
16	AMOUNT TO USE FOR RATE CALCULATION \$	16																										

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Aviston Terrace COUNTY Clinton

FACILITY IDPH LICENSE NUMBER 0036749

CONTACT PERSON REGARDING THIS REPORT Rob Keime

TELEPHONE (309) 685-0595 FAX #: (309) 685-8463

A. Summary of Real Estate Tax Costs

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>N/A</u>	<u></u>	\$ <u></u>	\$ <u></u>
2.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
3.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
4.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
5.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
6.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
7.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
8.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
9.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
10.	<u></u>	<u></u>	\$ <u></u>	\$ <u></u>
		TOTALS	\$ <u></u>	\$ <u></u>

B. Real Estate Tax Cost Allocation:

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 3,900 B. General Construction Type: Exterior Brick & Siding Frame Wood Number of Stories One

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground: (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO

If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
 3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Resident Care	26,400	1991	\$ 20,000	1
2					2
3	TOTALS	26,400		\$ 20,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace

0036749

Report Period Beginning:

07/01/2001 Ending: 06/30/2002

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	16	1991	1986	\$ 432,500	\$ 10,812	40	\$ 10,812		\$ 124,346
5									
6									
7									
8									
Improvement Type**									
9	Expand bedroom	1991		1,790	45	40	45		472
10	Sprinkler system	1993		603	116	5	116		1,032
11	Sprinkler system	1996		936	62	15	62		343
12	Sprinkler system	1998		1,274	85	15	85		297
13	Allocated from parent company			5					
14	Bathroom Toilets	2001		1,349	90	15	90		135
15	Bathroom Tiles	2001		2,720	181	15	181		272
16	Bathroom tile and drywall	2001		2,540	155	15	155		155
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
31									
32									
33									
34									
35									
36									

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 443,717	\$ 11,546		\$ 11,546	\$	\$ 127,052	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number **Aviston Terrace**# **0036749**

Report Period Beginning:

07/01/2001

Ending:

06/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 51,812	\$ 3,551	\$ 3,551	\$	5-10 years	\$ 42,783	71
72	Current Year Purchases	1,506	78	78		5-10 years	78	72
73	Fully Depreciated Assets							73
74	Parent company allocation			259	259			74
75	TOTALS	\$ 53,318	\$ 3,629	\$ 3,888	\$ 259		\$ 42,861	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	96 Buick Century	2002	\$ 4,500	\$ 450	\$ 450	\$	5	\$ 450	76
77	Facility Use	97 Chevy Astro Van	2002	8,000	800	800		5	800	77
78										78
79										79
80	TOTALS			\$ 12,500	\$ 1,250	\$ 1,250	\$		\$ 1,250	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 529,535	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 16,425	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 16,684	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 259	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 171,163	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ <u>N/A</u>			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized

by the length of the lease

N/A

N/A

N/A

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 67

Description: CPR valve and filter - \$67

(Attach a schedule detailing the breakdown of movable equipment)

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2003 \$ _____

13. _____/2004 \$ _____

14. _____/2005 \$ _____

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>Resident care</u>	<u>1996 Buick Century</u>	\$ <u>250.00</u>	\$ <u>1,500</u>	17
18	<u>Resident care</u>	<u>1997 Chevy Astro Van</u>	\$ <u>250.00</u>	\$ <u>1,500</u>	18
19					19
20	<u>Parent company allocation</u>			<u>11</u>	20
21	TOTAL		\$ <u>500.00</u>	\$ <u>3,011</u>	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	2. CLASSROOM PORTION:	3. CLINICAL PORTION:
		IN-HOUSE PROGRAM <input checked="" type="checkbox"/>	IN-HOUSE PROGRAM <input checked="" type="checkbox"/>
		IN OTHER FACILITY <input type="checkbox"/>	IN OTHER FACILITY <input type="checkbox"/>
		COMMUNITY COLLEGE <input type="checkbox"/>	HOURS PER AIDE <u>80</u>
		HOURS PER AIDE <u>40</u>	

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 1,066	\$	\$ 1,066
2	Books and Supplies		205		205
3	Classroom Wages (a)		1,809		1,809
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 3,080	\$	\$ 3,080
10	SUM OF line 9, col. 1 and 2 (e)	\$	3,080		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	2
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescripts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Pt. B MCR Supplies	L39, C8					444		444	13
14	TOTAL			\$		\$	\$ 444		\$ 444	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Aviston Terrace

0036749

Report Period Beginning: 07/01/2001

Ending:

06/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 4,195)	127,969	127,969	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	2,454	2,454	6
7	Other Prepaid Expenses	64,950	64,950	7
8	Accounts Receivable (owners or related parties)	801,889	801,889	8
9	Other(specify): <u>Prepaid Deposit</u>	5,700	5,700	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,002,962	\$ 1,002,962	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,000	20,000	13
14	Buildings, at Historical Cost	443,717	443,717	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	65,818	65,818	16
17	Accumulated Depreciation (book methods)	(171,163)	(171,163)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Loan Costs</u>	44,984	44,984	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 403,356	\$ 403,356	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,406,318	\$ 1,406,318	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 51,497	\$ 51,497	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	51,072	51,072	29
30	Accrued Salaries Payable	17,200	17,200	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	25,195	25,195	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	114,677	114,677	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 259,641	\$ 259,641	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	1,300	1,300	39
40	Mortgage Payable			40
41	Bonds Payable	631,210	631,210	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 632,510	\$ 632,510	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 892,151	\$ 892,151	46
47	TOTAL EQUITY (page 18, line 24)	\$ 514,167	\$ 514,167	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,406,318	\$ 1,406,318	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Aviston Terrace
Provider # 0036749
June 30,2002

XV. Balance Sheet

Schedule 17A

<u>Line 36-Other Current Liabilities</u>	<u>Operating</u>	<u>After Consolidating</u>
Accrued Respro	39,467	39,467
Accrued Expense	4,727	4,727
Accrued Workshop	46,695	46,695
Accrued Bond Payments	22,964	22,964
Resident Credit Balances	824	824
Total Line 36-Other Current Liabilities	<u>114,677</u>	<u>114,677</u>

See Accountants' Compilation Report

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 439,192	1
2	Restatements (describe):		2
3	Prior period adjustment	(5,104)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 434,088	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	145,101	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Parent company allocation	(65,022)	15
16	Other (describe) added back in column 7		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 80,079	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 514,167	24

Operating Entity Only

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Aviston Terrace

0036749

Report Period Beginning: 07/01/2001

Ending: 06/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 571,447	1
2	Discounts and Allowances for all Levels		2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 571,447	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
C. Other Operating Revenue			
9	Payments for Education	179,425	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	2,593	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 182,018	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	62	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 62	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	33	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 33	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 753,560	30

2			
	Expenses	Amount	
A. Operating Expenses			
31	General Services	66,977	31
32	Health Care	167,956	32
33	General Administration	102,624	33
B. Capital Expense			
34	Ownership	62,693	34
C. Ancillary Expense			
35	Special Cost Centers	182,158	35
36	Provider Participation Fee	26,051	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 608,459	40
41	Income before Income Taxes (line 30 minus line 40)**	145,101	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 145,101	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.
A federal tax return is filed for the combined divisions of Progressive Housing, Inc.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **Aviston Terrace**

0036749

Report Period Beginning: 07/01/2001

Ending:

06/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			\$	\$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	446	478	8,503	17.79	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees	248	248	1,809	7.29	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers					11
12	Dietician	1,976	2,172	18,451	8.49	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	582	585	3,730	6.38	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	786	850	16,813	19.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,388	1,560	26,157	16.77	29
30	Habilitation Aides (DD Homes)	13,297	14,268	116,854	8.19	30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	18,723	20,161	\$ 192,317 *	\$ 9.54	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	25	\$ 1,534	L1,C3	35
36	Medical Director	Monthly	1,200	L9,C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	507	L10,C3	39
40	Physical Therapy Consultant	3	274	L10A,C3	40
41	Occupational Therapy Consultant	2	33	L10A,C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	535	L10A,C3	43
44	Activity Consultant				44
45	Social Service Consultant	28	1,624	L12,C3	45
46	Other(specify) <u>Psychological</u>	Monthly	2,432	L10,C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	66	\$ 8,139		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	Ownership %	Amount
Kay Buscher	Administrative	0%	\$ 8,317
Alan Cary	Administrator	0%	8,496
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 16,813
B. Administrative - Other			
Description			Amount
Developmental Services of Illinois, Inc. - Administrative Service Fees			\$ 62,700
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 62,700
C. Professional Services			
Vendor/Payee	Type		Amount
Personnel Planners	U/C Consulting		\$ 200
Lawrence Manson	Legal		170
Marsha Holzhauer	Legal		300
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 670
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance			\$ 5,543
Unemployment Compensation Insurance			1,168
FICA Taxes			14,678
Employee Health Insurance			14,546
Employee Meals			2,722
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			611
TOTAL (agree to Schedule V, line 22, col.8)			\$ 39,268
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
			\$
N/A			
TOTAL			\$
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee			\$ 400
Advertising; Employee Recruitment			154
Health Care Worker Background Check (Indicate # of checks performed 8)			56
Illinois Health Care Association			927
Various Licenses & Fees			552
Various Dues & Subscriptions			296
Allocated from parent company			(3)
Less: Public Relations Expense		(
Non-allowable advertising		(
Yellow page advertising		(
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 2,382
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel			\$
In-State Travel			1,085
Seminar Expense			203
Allocated from parent company			(17)
Entertainment Expense		(
(agree to Sch. V, line 24, col. 8)			
TOTAL			\$ 1,271

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

****See instructions.**

Aviston Terrace**Provider #: 0036749****07/01/2001 to 06/30/2002****Schedule 21A****XIX. SUPPORT SCHEDULE****C. Professional Services****Total (agree to Schedule V, line 19, column 3) 670****Allocated from Progressive Housing, Inc.**

Altschuler, Melvoin & Glasser LLP	Accounting	6,283
American Express Tax & Business Services	Accounting	124
Lawrence Manson	Legal	1,346

Allocated from Parent Company

Altschuler, Melvoin & Glasser LLP	Accounting	399
American Express Tax & Business Services	Accounting	387
Heinold-Banwart	Accounting	678
Lawrence Manson	Legal	890

Less: Out of period legal fees (170)**Total (agree to Schedule V, line 19, column 8) 10,607****See Accountants' Compilation Report**

PROGRESSIVE HOUSING, INC.
LEGAL FEES ALLOCATION
June 30, 2002

Detailed legal invoice listing:

Lawrence Manson	960
Lawrence Manson	460
Lawrence Manson	1,900
Lawrence Manson	1,340
Lawrence Manson	720
Lawrence Manson	300
Lawrence Manson	2,180
Lawrence Manson	3,040
Lawrence Manson	460
	440
	<u>11,800</u>

	Aviston	Briarbrook	Harris	Joshua	Terra	Park	Perrine	Okawville	Western Gardens	Galaxy	Billy Goat Hill	Troy	CCH 185th	CCH Lee St.	Total
# of beds	16	16	16	16	16	16	4	6	4	8	8	4	6	6	142
Lawrence Manson	1,346	1,346	1,346	1,346	1,346	1,346	337	505	337	673	673	337	505	360	11,800
	<u>1,346</u>	<u>1,346</u>	<u>1,346</u>	<u>1,346</u>	<u>1,346</u>	<u>1,346</u>	<u>337</u>	<u>505</u>	<u>337</u>	<u>673</u>	<u>673</u>	<u>337</u>	<u>505</u>	<u>360</u>	<u>11,800</u>

SEE ACCOUNTANTS' COMPILATION REPORT

Center for Residential Management, Inc.
Professional Fees Allocation
June 30, 2002

Detailed legal invoice listing

American Express Tax & Business Services	Accounting	13,626	Lawrence Manson	3,260
Altschuler, Melvoin & Glasser LLP	Accounting	14,178	Lawrence Manson	4,360
Heinold-Banwart	Accounting	24,092	Lawrence Manson	1,300
Lawrence Manson	Legal	31,620	Lawrence Manson	5,600
			Lawrence Manson	360
Amount allocated through CRM allocation		83,516	Lawrence Manson	3,420
			Lawrence Manson	500
			Lawrence Manson	2,540
			Lawrence Manson	1,980
			Lawrence Manson	2,720
			Lawrence Manson	1,700
			Lawrence Manson	3,880
				31,620

	Lakeview	Countryview	Sparta	Ellner	Taylorville	Gateway	Aviston	Briarbrook	Harris	Joshua	Terra	Park Place	Perrine	Okawville	WGarden	Galaxy	Cardinal	BGHill	Troy	CCH 185th	CCH Lee St.	Mt. Vernon	Jeffersonian	Casey	TOTAL
bed days available	52,925	-	5,840	5,840	5,840	-	5,840	5,840	5,840	5,840	5,840	5,840	1,460	2,190	1,460	2,920	-	2,920	1,460	2,190	1,638	23,360	23,725	38,690	207,498
Alloc. Percentage	0.255063	0.000000	0.028145	0.028145	0.028145	0.000000	0.028145	0.028145	0.028145	0.028145	0.028145	0.028145	0.007036	0.010554	0.007036	0.014072	0.000000	0.014072	0.007036	0.010554	0.007894	0.112579	0.114338	0.186460	1.000000
American Express Tax & Business Services	3,512	-	387	387	387	-	387	387	387	387	387	387	83	128	80	176	-	176	80	128	92	1,551	1,575	2,568	13,626
Altschuler, Melvoin & Glasser LLP	3,616	-	399	399	399	-	399	399	399	399	399	399	100	150	100	200	-	200	100	150	112	1,596	1,621	2,644	14,178
Heinold-Banwart	6,145	-	678	678	678	-	678	678	678	678	678	678	170	254	170	339	-	339	170	254	190	2,712	2,755	4,492	24,092
Lawrence Manson	8,065	-	890	890	890	-	890	890	890	890	890	890	222	334	222	445	-	445	222	334	250	3,560	3,615	5,896	31,620
	21,339	-	2,354	2,354	2,354	-	2,354	2,354	2,354	2,354	2,354	2,354	575	865	572	1,159	-	1,159	572	865	643	9,419	9,566	15,599	83,516

See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3						N/A							
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Aviston Terrace

STATE OF ILLINOIS

0036749

Report Period Beginning: 07/01/2001

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Ending: 06/30/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association - \$927
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7.5 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line N/A
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 34,736
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
See attached Schedule 23A
SEE ACCOUNTANTS' COMPILATION REPORT
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ 2,722 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
c. What percent of all travel expense relates to transportation of nurses and patients? 40%
d. Have vehicle usage logs been maintained? Adequate records have been maintained.
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Altschuler, Melvoin & Glasser LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit currently in progress
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.

Aviston Terrace
 Provider # 0036749
 RSD Salaries Allocation
 06/30/02

Schedule 23A

	Name of RSD	Number of Residents	X	Number of Hours Req'd	X	Weeks per year	=	Total Hours	/	Total hours paid	X	Total RSD Wages per Trial Balance	=	Total Reclassified to RSD (In 10)	Total Remaining in Administrative Salaries (In 17)
Aviston	Kay Buscher	15		2		52		1,560		2,056		34,474		26,157.32	8,317

Rule 350.3740 requires a minimum Resident Services Coordinator staffing of two hours per week per resident. We allocated wages between the Nursing/Programs section of the cost report with the remainder left in Administrative.

See Accountants' Compilation Report

RECONCILIATION REPORT

Aviston Terrace

02:11 PM 11/04/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-116,041	equal to	-116,041	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	47,006	equal to	47,006	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	16,684	equal to	16,684	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	3,078	equal to	3,078	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	3,080	equal to	3,080	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv. - Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	842	equal to	842	0	O.K.	Pg16 Z12+Z14...	N/A/B	1-4,40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv. - Supplies	444	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	66,977	equal to	66,977	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	167,956	equal to	167,956	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	102,624	equal to	102,624	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	62,693	equal to	62,693	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	182,158	equal to	182,158	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+†	N/A	38to41+43	4
Income Stat. Prov. Partic.	26,051	equal to	26,051	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	151,514	equal to	151,514	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	1,809	< or = to	1,809	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	0	equal to	0	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	0	equal to	0	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	18,451	equal to	18,451	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	3,730	equal to	3,730	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	0	equal to	0	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	0	equal to	0	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	16,813	equal to	16,813	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	0	equal to	0	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	192,317	equal to	192,317	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	1,534	< or = to	1,534	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	1,200	< or = to	1,200	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	507	< or = to	2,939	-2,432	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to	97	-97	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,624	< or = to	1,624	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	16,813	equal to	16,813	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	62,700	equal to	62,700	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	670	equal to	670	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	39,268	equal to	39,268	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,382	equal to	2,382	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,271	equal to	1,271	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	34,736	equal to	26,051	8,685	FAILED	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	2,722	< or = to	24,474	-21,752	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	2,722	equal to	2,722	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	1,809	equal to	1,809	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	66,403	equal to	66,403	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4†	B.	14	8
Total loan balance	683,582	equal to	683,582	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	20,000	equal to	20,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	443,717	equal to	443,717	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	65,818	equal to	65,818	0	O.K.	Pg13 O22+L13	C. & D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	171,163	equal to	171,163	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	514,167	equal to	514,167	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	145,101	equal to	145,101	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,406,318	equal to	1,406,318	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustmen	Adjusted Total
1. Dietary	18,451	1,433	1,534	21,418	0	21,418	0	21,418
2. Food P	0	22,963	0	22,963	0	22,963	-2,722	20,241
3. Housek	0	2,971	0	2,971	0	2,971	0	2,971
4. Laundry	0	726	0	726	0	726	0	726
5. Heat ar	0	0	7,992	7,992	0	7,992	0	7,992
6. Mainte	3,730	0	7,177	10,907	0	10,907	31	10,938
7. Other (0	0	0	0	0	0	0	0
8. Total G	22,181	28,093	16,703	66,977	0	66,977	-2,691	64,286
9. Medical	0	0	1,200	1,200	0	1,200	0	1,200
10. Nursin	151,514	1,533	2,939	155,986	0	155,986	0	155,986
10a. Ther	0	0	842	842	0	842	0	842
11. Activi	0	2,664	97	2,761	0	2,761	0	2,761
12. Social	0	0	1,624	1,624	0	1,624	0	1,624
13. Nurse	1,809	0	1,271	3,080	0	3,080	0	3,080
14. Progr	0	0	704	704	0	704	0	704
15. Other	0	0	1,759	1,759	0	1,759	0	1,759
16. Total I	153,323	4,197	10,436	167,956	0	167,956	0	167,956
17. Admin	16,813	0	62,700	79,513	0	79,513	5,700	85,213
18. Direct	0	0	0	0	0	0	4,576	4,576
19. Profes	0	0	670	670	0	670	9,937	10,607
20. Fees,	0	0	2,307	2,307	0	2,307	75	2,382
21. Cleric	0	1,229	3,026	4,255	0	4,255	5,443	9,698
22. Emplo	0	0	14,794	14,794	0	14,794	24,474	39,268
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	796	796	0	796	475	1,271
25. Other	0	0	1,040	1,040	0	1,040	265	1,305
26. Insura	0	0	-751	-751	0	-751	4,659	3,908
27. Other	0	0	0	0	0	0	0	0
28. Total C	16,813	1,229	84,582	102,624	0	102,624	55,604	158,228
29. Total C	192,317	33,519	111,721	337,557	0	337,557	52,913	390,470
30. Depre	0	0	16,425	16,425	0	16,425	259	16,684
31. Amort	0	0	0	0	0	0	0	0
32. Intere	0	0	43,201	43,201	0	43,201	3,805	47,006
33. Real E	0	0	0	0	0	0	0	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	3,067	3,067	0	3,067	11	3,078
36. Other	0	0	0	0	0	0	0	0
37. Total C	0	0	62,693	62,693	0	62,693	4,075	66,768
38. Medic	0	0	0	0	0	0	0	0
39. Ancill	0	0	0	0	0	0	444	444
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	26,051	26,051	0	26,051	8,685	34,736
43. Other	0	0	182,158	182,158	0	182,158	-182,158	0
44. Total S	0	0	208,209	208,209	0	208,209	-173,029	35,180
45. Grand	192,317	33,519	382,623	608,459	0	608,459	-116,041	492,418

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	0	0
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Receivable	127,969	127,969
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	2,454	2,454
7. Other Prepaid Expenses	64,950	64,950
8. Accounts Receivable-Owner/Related Party	801,889	801,889
9. Other (specify):	5,700	5,700
10. Total current assets	1,001,852	1,001,852
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	20,000	20,000
14. Buildings, at Historical Cost	443,717	443,717
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	65,818	65,818
17. Accumulated Depreciation (book methods)	-171,163	-171,163
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	44,984	44,984
24. Total Long-Term Assets	403,356	403,356
25. Total Assets	1,405,208	1,405,208
CURRENT LIABILITIES		
26. Accounts Payable	51,497	51,497
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	51,072	51,072
30. Accrued Salaries Payable	17,200	17,200
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	25,195	25,195
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	114,677	114,677
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	258,531	258,531
LONG TERM LIABILITES		
39. Long-Term Notes Payable	1,300	1,300
40. Mortgage Payable	0	0
41. Bonds Payable	631,210	631,210
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	0	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	632,510	632,510
46. Total Liabilities	891,041	891,041
47. Total Equity	514,167	514,167
48. Total Liabilities and Equity	1,405,208	1,405,208

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	571,447
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	571,447
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Ancillary Revenue	-
9. Payments for Education	179,425
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	2,593
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	182,018
24. Contributions	0
25. Interest and Other Investments Income	62
Subtotal - Non-Operating Revenue	62
27. Other Revenue (specify):	33
28. Other Revenue (specify):	0
Subtotal - Other Revenue	33
30. Total Revenue	753,560
31. General Services	680,120
32. Health Care	1,154,988
33. General Administration	668,561
34. Ownership	144,710
35. Special Cost Centers	60,174
35. Provider Participation Fee	41,063
37. Other	0
40. Total Expenses	2,749,616
41. Income Before Income Taxes	-1,996,056
42. Income Taxes	0
43. Net Income or Loss for the Year	-1,996,056

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9 Line 16 for mortgage insurance.

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